Access to reproductive health services and education in indigenous communities

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SUMMARY

One of the main problems that reproductive health programs in Guatemala face is how to provide culturally appropriate services to the indigenous population. In March, 1997, AGES completed an operations research project in which teachers of the National Bilingual Education Program (PRONEBI) taught reproductive health courses in indigenous communities, in indigenous languages. To screen out unmotivated teachers, AGES required that they pass an exam on an extensive list of readings. Those passing the exam and attending a workshop were approved to teach 10-hour courses in their communities. Teachers were paid US $22 per course. Fifty-five teachers completed the full process of examination, training and giving at least one course. A total of 496 courses for 11,171 students were taught in a seven-month period. The contraceptive prevalence rate of married participants increased by at least three percentage points after the course (equivalent to an increase of 18% in use of all methods, and of 40% in the use of modern methods). Sixty five percent of those not married or in union and of those not yet using methods said they expected to use a family planning method in the near future. The cost per course was US $56.40, and per student US $2.50. Nevertheless, the strategy was criticized in terms of the weak linkages that it established with services. It was felt that the use of methods would have increased more if stronger links with services had been established.

The objective of this project was to replicate the educational strategy tested in the previous project and to test components to strengthen its links to service delivery. These included a) inviting teachers to become CBD distributors; b) requiring that links with services be established before teachers wee allowed to give courses; c) conducting segmentation meetings in the classes to screen students for their need for services, and referring them to designated outlets

The project was conducted in the departments of Chimaltenango, Quezaltenango, San Marcos, Sololá and Totonicapán. In less than three months, 45 teachers taught 214 family planning courses to 3,195 students, and 84 courses on pregnancy and child care to 1,260 students. Service delivery activities were less successful. Few teachers distributed contraceptives in their communities, partly because AGES was unable to obtain a price that could compete with that offered by APROFAM CBD distributors. A total of 595 referrals were made for health services, but of these, only 46 were for family planning. Two proposed additional service delivery components –offering IUD insertions in rural communities and accompanying groups of seven or more women to clinics to obtain long –term contraceptive methods were not tested for different reasons.

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I. INTRODUCTION

1.1 Population and Reproductive Health in Guatemala.

Guatemala has a crude birth rate of 36 births per one thousand inhabitants, second only to Belize's in the Americas (Population Reference Bureau, 1996). The total population is estimated at 10 million, of which 60% are Spanish speakers (locally called *Ladinos*) and 40% are speakers of one of the 22 Mayan languages spoken in Guatemala. The indigenous population is statistically much worse off than the Ladino population in just about every social and health indicator. With regards to contraception, the 1995 Maternal-Child Health National Survey found a prevalence of 10% for Mayans and of 40% for Ladinos. Although the conventional wisdom is that Mayans reject family planning, studies have shown that indigenous women are aware of the deleterious effects of having too many children and having children too closely spaced. Several qualitative studies have also found an almost universal desire to know more about birth spacing, especially of natural methods (modern methods are distrusted and referred to as "artificial.") (Rosenhouse et al, 1989; Ward et al, 1990; Ward et al, 1992; Toj et al, 1995; Pineda et al, 1995). These results have led many analysts to believe that the low acceptance of family planning is more related to the lack of culturally appropriate, accessible services: few institutions are prepared to provide either education or services in any of the 24 indigenous languages spoken in Guatemala.

1.2 AGES

The Asociación Guatemalteca de Educación Sexual y Desarrollo Humano (AGES) is a private, non-profit institution founded in 1978 in order to provide culturally appropriate sex education and reproductive health services and information. AGES main offices are located in Guatemala City, and it has offices in the departments of Chimaltenango, Quetzaltenango, San Marcos and Huehuetenango.

AGES main activities include: a) sex education courses and workshops for children, teenagers, parents and indigenous populations; b) development of sex education and reproductive health information, education and communication (IEC) materials, both in Spanish and in Mayan languages; c) scholarships for Mayan girls to further the education of girls; d) providing reproductive health education and contraceptive services to adolescents through a peer promotion program in Guatemala City, Huehuetenango, Quetzaltenango and San Marcos; and e) a program for homeless girls to bring gender and reproductive health education to girls in Guatemala City in order to modify high risk sexual behaviors.

One of the main interests of AGES is achieving financial self-sufficiency to conduct its projects. Currently, AGES covers around 40% of its financial needs by means of a publishing

department, library services and sales and rent of audiovisual material such as slides, videos and films.

II PROBLEM STATEMENT

In March 1997, AGES completed an innovative operations research project (funded by the INOPAL III project) in which teachers of the National Bilingual Education Program (PRONEBI) taught reproductive health courses in indigenous communities[1]. Briefly described, as part of the strategy:

a) AGES developed three 10-hour courses or "modules" that PRONEBI teachers could teach in their communities: birth spacing; pregnancy, birth and gender; and mother and baby care;

b) PRONEBI teachers in the departments of Chimaltenango, Quetzaltenango and San Marcos were invited to participate in the Reproductive Health Education System. To participate on the system, teachers had to pass a written examination based on a list of readings (about 100 pages for each module), and attend a 12-hour training course for each module. Once the teacher passed the exam and attended the training course, he or she was considered to be "certified" to teach the module;

c) Certified teachers assembled groups and taught the courses in their communities. At the end of the course, they were paid 125 quetzals (US $ 22) for each 10-hour reproductive health course taught in indigenous communities in the local indigenous language.

The results were very satisfactory: a total of 55 teachers completed the full process of examination, training and giving at least one course. A total of 496 courses for 11,171 students were taught in a seven-month period. About 38% of the students who attended the courses were male, and nearly 47% were under 20 years of age. All students were speakers of a Mayan language, and the majority reported liking the course. The contraceptive prevalence rate of married participants increased by at least three percentage points after the course (equivalent to an increase of 18% in use of all methods, and of 40% in the use of modern methods). Sixty five percent of those not married or in union and of those not yet using methods said they expected to use a family planning method in the near future. The cost per course was US $56.40, and per student US $2.50.

On the one hand, these results were so interesting that AGES felt that the strategy should be extended to other areas. On the other hand, beyond its lack of potential sustainability, the strategy was criticized in terms of the weak linkages that it established with services. Although the strategy required that bilingual teachers invited to their courses at least two service delivery agents of the community or its environs, in many cases this requirement was not met. Given the

[1] See Cospín, Gloria and Ricardo Vernon. 1997. Reproductive Health Education in Indigenous Areas Through Bilingual Teachers in Guatemala. Final report. AGES and Population Council, Guatemala City, Guatemala, April.

strong unmet need of participants, it was felt that if the strategy had more solid linkages with services, the use of contraceptive methods would have increased even more than observed in the experiment.

III PROBLEM SOLUTION

AGES thought that the following activities could help strengthen the linkages with service providers and, thus, the impact of the courses:

a) Train participating teachers as CBD distributors.

b) For those not willing to be CBD distributors or not accepted by APROFAM as distributors, require and verify that linkages with nearby service delivery agents be established before the courses were taught.

c) Establish a strong referral system to services, based on the screening of the need for reproductive health services and on the direct interaction of teachers and service providers.

d) Make it possible for the teacher or the AGES supervisor to take groups of women desiring long term methods (IUD and sterilization) to clinics providing this services.

e) Make agreements with physicians for the delivery of IUD insertions in remote communities where a large group of women want this method, or in their own clinics when established in remote communities.

IV. OBJECTIVE

The general objective of this project was to test the effects of adding service delivery components to the activities included in the Reproductive Health Education System (RHES) in terms of the acceptability of the educational system and the use of services by participants in the courses.

The service delivery components were tested as a follow-up component in the case of the areas where courses have already been given (in the departments of Chimaltenango, Quetzaltenango and San Marcos). In the new project areas of Sololá and Totonicapán, it was tested as an integral part of the RHES.

V. METHODOLOGY

5.1 Project Sites

The project was conducted in areas where the bilingual-teacher strategy had not been tested before (the departments of Sololá and Totonicapán), and in Chimaltenango, Quetzaltenango and San Marcos, where the previous project was conducted.

5.2 Operations Research Activities

The following operations research activities were proposed:

a) *Recruitment and training of teachers*: in both new and old project areas, teachers were invited to participate in the Reproductive Health Education System (RHES). Those interested in teaching a module were given a brochure with readings of about 100 pages and were invited to take an exam on these readings. The two modules that were made available were birth spacing and care of the mother and the child. The exams used to test the knowledge of students are presented as Appendix 1. In both exams, in addition to the technical contents, several questions were used to evaluate the impact of gender and reproductive rights contents included in both modules.

   Those who passed the exam were invited to attend a 12-hour workshop in which educational materials and techniques were reviewed, data collection instruments were handed out, and the characteristics of the RHES were explained. In addition, the teachers learned how to use the ALGOSISSAR. These are interactive guides developed by the INOPAL project and the MOH of Guatemala that give step by step instructions to help CBD distributors and clinical providers deliver contraceptive services, and which have been proven to decrease training needs to a few hours. Teachers who had participated in the previous project could participate directly in this project.

b) *Invitation and training of bilingual teachers to become CBD distributors*: teachers were given an initial stock of pills, condoms and IUDs to distribute in their communities. AGES received on consignment these contraceptives form APROFAM, the local family planning association, and then gave the contraceptives on consignment to the teachers. The intention was that APROFAM would decide in the following months which of these teachers could become distributors in their CBD program based on their performance.

c) *Establishment of linkages with service providers*: in order to strengthen the relationships with service providers, teachers were required to visit at least two service providers before teaching any courses, including one provider of IUD and sterilization services. During their visits, teachers were supposed to agree on referral mechanisms, prices for services, and days and hours of service. The AGES field coordinator verified that this contact had taken place and the service provider was willing to participate in project activities, including keeping the referral slips developed for the project (see Appendix 2) and statistics needed.

d) *Teaching of courses, segmentation meetings and referrals*: the teachers began assembling groups and teaching the courses after their training and visit to community service providers.

Two courses were taught: “Birth Spacing” and “Care of Mother and Child.” At the end of each course, the teacher conducted a meeting to assess the reproductive health needs of participants (i.e., segmented the participants according to needs) and referred the participants to those services they wanted. The segmentations exercise was conducted posing the wix questions of the ALGOSISAR, an algorithm developed for use in health centers in Guatemala. Essentially, the segments and actions taken for each were the following:

- Single, not sexually active, not pregnant: no further action
- Pregnant: verify prenatal care and refer to services if not receiving.
- Married or in union, not pregnant, using a method: verify satisfaction with method used and give refresher on method use.
- Married or in union, not pregnant, not using a method, wishing a pregnancy: advise women to attend course on pregnancy and to attend prenatal care as soon as they get pregnant.
- Married, not pregnant, not using a method, not wishing a pregnancy, wishing a method: provide counseling and refer or accompany to services.
- married, not pregnant, not using a method, not wishing a method: provide counseling, offer support when she decides to use one.

The teacher gave each student a referral slip (see Appendix 2). The service providers kept these slips, which were collected by the AGES field coordinator near the end of the project.

The teachers were paid 140 Q for each 10-hour course given.

Teachers who had participated in the first project were given the chance to conduct segmentation meetings with the students who had attended the courses in the first project. In this case, they were offered 35Q for each segmentation meeting they conducted.

e) *Escorting groups of women desiring long-term methods to clinics*: because clinics tend to be far away, many women in indigenous communities are monolingual, and are reluctant to attend facilities where their language is not spoken, AGES proposed that teachers be reimbursed travel and per-diem expenses when they accompanied groups of at least four women wishing long term methods (IUD and sterilization) to clinics.

f) *IUD community service delivery posts*: to guarantee access to the IUD in remote communities, AGES proposed to identify physicians who were willing to travel to remote communities where teachers identified a minimum of seven women wanting an insertion. In this case, the woman was to be charged a price equivalent to that paid in APROFAM, and the physician was to be paid a flat rate of 125 Quetzales per trip, plus travel and perdiem expenses.

5.3 Variables

The following variables were used to evaluate the courses:

a) Effectiveness of the educational strategy to recruit motivated teachers, measured as the number and proportion of teachers who registered for the exam, underwent training and taught at least one course in the communities.

b) Acceptability of the courses for the indigenous population, measured as the number of courses and number of students registered for the different courses.

c) Effectiveness of the strategy to improve the accessibility to contraception, measured as the number of teachers who became CBD distributors, the number who actually distributed methods, the number who accompanied groups of women desiring a long term method to a clinic, the number of groups organized, the number of teachers who organized IUD insertion sessions in remote communities, and the number of sessions organized.

d) Impact of the courses on use of services, measured as the number and proportion of students who attended a local service delivery outlet to receive the different reproductive health services, the number who participated in IUD insertion sessions, and the number who went in groups to clinics to obtain a long term method.

5.4 Sources of information.

The following sources of information were used to evaluate the strategy:

a) Exam enrollment records, records of attendance to segmentation meetings and AGES records were used to evaluate the effectiveness of the educational strategy to recruit motivated teachers.

b) Course log books collected information on the number of students who participated in courses and segmentation exercises. (Appendix 3)

c) Referral slips collected at service delivery sites were used to evaluate the impact of the strategy on generating demand for services. (Appendix 2)

d) Other sources of information presented in the text included 1) 27 reports of supervision visits by AGES is five field coordinators; 2) a final qualitative report sent by these coordinators; and 3) a report sent by two Dutch students doing field work for their nursing studies who made a qualitative evaluation of activities conducted in San Marcos. (Appendix 4)

VI RESULTS

6.1 Recruitment and Training of Teachers

Table 1 shows that a total of 53 teachers took the examination to teach the birth spacing course, that 45 passed this exam and that 34 went on two assemble groups and teach courses. In the case of the Care of Mother and Child module, 18 bilingual teachers taught at least one course. Except for four teachers in San Marcos, all bilingual teachers were new to the Reproductive Health Education System, even those participating in Chimaltenango, Quetzaltenango and San Marcos, where the first project was conducted. The majority of teachers who were given the reading materials and took the exam had studied them sufficiently to pass it. Average scores of those taking the exam were close to 80/100 points, but these grades include those of students failing the exam.

6.2 Establishment of CBD Posts

The exams and follow-up training was considered by AGES to be sufficient to let bilingual teachers become CBD distributors. AGES obtained from APROFAM 1000 pill cycles and 100 TCu IUDs on consignment and gave an initial stock of contraceptives to all teachers who gave courses. However, at the end of the second month, only nine pill cycles and one IUD had been sold, so AGES decided to recall the contraceptives from the teachers and return them to APROFAM. The main problem for the establishment of CBD posts was that AGES purchased the pill cycles from APROFAM at the same price than APROFAM CBD distributors, so it was difficult to establish a competitive price at communities. The supervisors and teachers also offered as an explanation for the lack of sales the conservatism of the communities where they worked and lack of demand.

6.3 Establishment of Linkages with Service Providers

In contrast to the previous project, AGES field coordinators reported all teachers had made linkages with service providers in their communities. In 75% of the 27 courses that were directly supervised, the AGES field coordinators observed that there was at least one service provider in the session. In over 90% of the cases, the teachers reported that service providers had been very willing to cooperate in the different activities, although in some cases they did not agree to attend the course sessions because that would have meant closing the health post.

6.4 Teaching of Courses, Segmentation Meetings and Referrals

Table 1 shows that a total of 214 Birth Spacing and 84 Care of the Mother and the Child courses were taught in indigenous communities. Approximately 55% of the courses were given in Kakchiquel, 17% in Kiché and 28% in Mam. A total of 3,195 students attended the Birth Spacing course and 1,260 the Care of the Mother and the Child course, i.e., close to 15 students per course on average. The largest number of courses was given in the new project areas of Totonicapán and Sololá, and in Chimaltenango. According to supervision reports, in the observed sessions most students were quite interested in the classes and had a positive attitude towards them. The Dutch students observed that groups were too large and too heterogeneous (too many adolescents and women over 35 years of age, too few married men, etc). They also

thought that many courses were given in only two, three or four sessions, so that sessions were too long and too much information was presented in them. Finally, they also felt that some sort of follow-up should be conducted after the end of the course in order to achieve the desired behavioral changes.

The supervisors reported that the teachers were very satisfied with the strategy tested and that service providers had attended at least once in most of the courses. In most cases, supervisors reported receiving support from community leaders for the activity, although there were a few exceptions. Only one problem in a community was reported as a consequence of the courses: in Totonicapán, the MOH Area Chief actively opposed the courses because, according to him, they ran against the local traditions. Nevertheless, also in Totonicapán, the director of a radio station (Radio Nacional TGTU) learned about the courses and invited the teachers and AGES supervisor to present the contents of the Birth Spacing module both in Kiché and Spanish. In total 13 programs were broadcast.

At the beginning it was proposed that teachers who had been trained in the previous project conducted segmentation meetings with the students who had attended the courses. However, only four of these meetings were conducted because the teachers felt that the payment (35 Q, about US $ 6), was not attractive enough considering the effort required in assembling the students and conducting one single session. Nevertheless, most of the courses that were taught by the teachers concluded with a segmentation exercise in the last session. According to different observers, these sessions did not work well: they took too much time, some students were reported to be suspicious or fearful of being sterilized without their consent. Even when the students wanted to receive a referral, they preferred to approach the teacher in private or wait until after their husbands had been consulted. Both the supervisors and the Dutch students considered that the teachers had not understood how to conduct the segmentation meetings or what their purpose was. They also did not understand well how to use the referral coupons. Further studies should be conducted on this.

A few supervisors and the Dutch students reported that the relationship with the MOH had not worked very well. Different observers mentioned that people were usually reluctant to attend health centers because they felt their services were of very bad quality. Often the centers did not have medicines available, and patients were made to wait or were denied the service because health centers attend only a pre-set number of clients or only provide one kind of service per day, such as prenatal care, etc. For these reasons, when possible, they prefer to go to private physicians, pharmacists and traditional birth attendants. The Dutch students felt that initial meetings with the Area and District heads should have been conducted and agreements made to obtain better results in terms of the way these referrals were cared for. These students also felt that central supervision from AGES had been missing.

Table 2 shows that a total of 595 effective referrals (evidenced by a referral coupon at the service delivery site) were made during the duration of the project. More than one third of these referrals were for common illnesses, and 377 were for reproductive health services, including well baby care and vaccinations (119), Pap test (78), prenatal care (70), post-natal care (51) and family planning (46). Thus, despite the high levels of unmet need for contraception, bilingual

teachers were able to refer less than one person for every 100 students who attended the courses in approximately two and one half months. In addition to the fact that referrals were followed up only two months after the beginning of activities, it should be considered that service providers reported that many students attended the health services but did not bring their referral coupons with them.

6.5 Escorting groups of women desiring long-term methods to clinics

This activity was not conducted by AGES because when it was discussed with field coordinators and teachers they felt that people were likely to felt threatened or pressed to make a decision for using a method.

6.6 IUD community service delivery posts

The advice of the USAID Mission not to implement this activity was followed. This advice was given attending the political conditions at the time the study was implemented.

VII CONCLUSIONS AND RECOMMENDATIONS

The objectives of this project were to replicate the educational strategy tested in a previous project and to observe if service delivery links could be added to the strategy to make it more effective.

The replication confirmed that the strategy is an excellent means to provide education in indigenous communities. Once again, it was observed that a few bilingual, motivated teachers could study the topics by themselves (which helps to reduce training costs) and then go on and provide courses in indigenous languages in remote rural communities. Further, in contrast to other experiences, which have tried to provide family planning education in indigenous communities, no negative consequences were observed in the teaching of these courses.

The introduction of service delivery components was not as successful as the educational strategy itself. This lack of success was a result of different factors, including the lack of contraceptives at a competitive price, cultural conservatism in indigenous communities and the political situation, which made AGES and the USAID mission prefer not to test two of the proposed strategies to increase access of long term methods for rural inhabitants. In Peru and Paraguay, these strategies have proven effective to satisfy the needs of rural populations, so a future test at more auspicious times should be conducted.

The referrals seem to work moderately well. Both the Dutch students and the AGES field coordinators observed that teachers did not understood how to conduct the segmentation exercise and that the purpose of the exercise was to identify persons needing and wanting the different reproductive health services, and to facilitate meeting these needs by pinpointing providers who could give them the services. In addition, the Dutch students considered that a greater follow up effort should be made. These would seem to be valuable suggestions to improve these strategies.

LIST OF TABLES

TABLE 1

NUMBER OF BILINGUAL WHO PRESENTED A TEST, WERE TRAINED AND GAVE COURSES, AND NUMBER OF COURSES GIVEN AND STUDENTS ATTENDING COURSE BY DEPARTMENT

MODULE/ VARIABLE	DEPARTMENT					
	CHIMAL-TENANGO	QUETZAL-TENANGO	SAN MARCOS	TOTONI-CAPAN	SOLOLÁ	TOTAL
BIRTH SPACING MODULE:						
No. Teachers who Presented Exam	10	9	9	14	11	53
Mean Test Score	66	77	79	77	83	76
No. of Teachers Trained	5	7	8	14	11	45
Number who Taught at Least One Course	5	6	8	9	7	34
Number of Courses Taught	55	28	33	62	36	214
Number of People Attending Courses	840	420	480	930	540	3195
CARE OF MOTHER AND CHILD MODULE:						
No. Teachers who Presented Exam	5	0	NA	7	5	NA
Mean Test Score	77	0	NA	76	83	NA
No. of Teachers Trained	5	0	NA	7	4	NA
Number who Taught at Least One Course	4	0	4	6	4	18
Number of Courses Taught	29	0	8	37	9	84
Number of People Attending Courses	435	0	135	555	135	1260

NA: Not Available

TABLE 2

NUMBER OF EFFECTIVE REFERENCES TO DIFFERENT REPRODUCTIVE HEALTH SERVICES
BY SERVICE AND DEPARTMENT

TYPE OF SERVICE	DEPARTMENT					
	CHIMAL-TENANGO	QUETZAL-TENANGO	SAN MARCOS	TOTONI-CAPAN	SOLOLÁ	TOTAL
Family Planning	7	13	0	3	23	46
Prenatal Care	43	0	16	5	6	70
Post natal care	40	0	5	0	6	51
Pap test	0	14	10	54	0	78
Menstrual Problems	0	0	9	0	2	11
Infertility	0	0	2	0	0	2
Well Baby Care	22	5	19	18	55	119
Common Illness	72	17	28	33	68	218
TOTAL	184	49	89	113	160	595

LIST OF APPENDICES – *NOT AVAILABLE*